IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 70030500000319669975

September 19, 2008

Denise Alexander, Administrator
Valley Vista Care Center of Sandpoint
220 South Division
Sandpoint, ID 83864

Provider #: 135055

Dear Ms. Alexander:

On **September 10, 2008**, a Facility Fire Safety and Construction survey was conducted at Valley Vista Care Center Of Sandpoint by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. **This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567L, listing Medicare/Medicaid deficiencies, and a similar form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each Federal/State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance. NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567L and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.**

Your Plan of Correction (PoC) for the deficiencies must be submitted by **October 2, 2008**. Failure to submit an acceptable PoC by **October 2, 2008**, may result in the imposition of civil monetary penalties by **October 22, 2008**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **October 15, 2008 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **October 15, 2008**. A change in the seriousness of the deficiencies on **October 15, 2008**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **October 15, 2008** includes the following:

Denial of payment for new admissions effective **December 10, 2008**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **March 10, 2009**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Mark P. Grimes, Supervisor,

Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0036, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **September 10, 2008** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach1.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach2.pdf

This request must be received by **October 2, 2008**. If your request for informal dispute resolution is received after **October 2, 2008**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

Mark P. Grimes
Supervisor
Facility Fire Safety and Construction

MPG/lj

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135055	A. BUILDING 01 B. WING _____	09/10/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VISTA CARE CTR OF SANDPOINT	220 SOUTH DIVISION SANDPOINT, ID 83864

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The facility is a single story structure of Type V(111) construction. The building is protected throughout by an automatic fire extinguishing system and a fire alarm system. The building was originally constructed in 1959 with an addition in 1985. There have been several minor additions and remodels with a major remodeling completed in 2001. The facility currently is licensed for 73 SNF/NF beds. The following deficiencies were cited during the annual fire/life safety survey conducted on September 10, 2008. The facility was surveyed under the Life Safety Code 2000 Edition, Existing Health Care Occupancy and in accordance with 42 CFR 483.70. The surveyor conducting the survey was: Eric Mundell REHS Health Facility Surveyor Facility Fire/Life Safety and Construction Program	K 000	These items of correction will be monitored by: Michael Lambert on a monthly basis	
K 017 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated	K 017	Remove hollow core door with grille, and replace with solid core door with self closer, by Oct. 24, 2008. Note: room is protected by sprinkler	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 10-9-08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 017	Continued From page 1 walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This Standard is not met as evidenced by: Based on observation, it was determined that a transfer grille was installed in an electrical control room door. The census was 68. The findings include: Observation on September 9, 2008 at 3:15 p.m., disclosed that the electrical control/panel room adjacent to the kitchen was equipped with a transfer grille in a hollow core door. With transfer grilles prohibited; lack of a solid, complete door would allow any smoke or heat from an electrical malfunction to infiltrate into other areas of the facility and provide cause to potentially affect 68 of 68 residents. This condition was observed by staff and surveyor.	K 017		
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are	K 029	Install self closer on door at Central supply. By Sept. 30, 2008	

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K 029	Continued From page 2 permitted. 19.3.2.1 This Standard is not met as evidenced by: Based on observation it was determined that the facility had not ensured a self-closing door was operational at the entry for the central supply room. Census on the date of the survey was 68. The findings include: Observation on September 10, 2008 at 10:06 a.m., disclosed that the corridor door installed for the central supply area was not a self-closing type. The corridor door was labeled "Central Supply" and the room was located adjacent to the corridor within the confines of the the "Cottage" quarters. Lack of a self-closing door would allow smoke to permeate the corridors of the 100 wing. This was observed by the maintenance engineer and surveyor. This has the potential to affect all of the residents and staff working in and around the five occupied sleeping rooms sampled and located in the 100 wing.	K 029		
K 043 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Patient room doors are arranged so that the patient can open the door from inside without using a key. (Special door locking arrangements are permitted in mental health facilities.) 19.2.2.2.2 This Standard is not met as evidenced by: Based on observation, it was determined that the	K 043	✓ Disable magnetic portion of locking system of both sets of doors (at room 401 & 501/502) No longer allowing doors to lock closed. By Sept. 30, 2008	

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K 043	Continued From page 3 facility had not ensured that the egress path through corridors would allow unobstructed access to exits by residents occupying 19 of 36 sampled sleeping rooms. The census was 68. The findings include: Observation on September 9, 2008 at 4:00 p.m. disclosed that with 400 and 500 wing primary or secondary corridor egress access blocked by magnetically locked cross corridor doors, this configuration would require some occupants to pass through at least three of those locked doors to exit the building. Access through the locked cross corridor door sets was only by code entry on a keypad , the code for which was "typically unknown" by residents. Proceeding from the magnetically locked cross corridor door located adjacent to sleeping room 401, a resident would confront the magnetically locked "Lodge" corridor doors (e.g., a special care unit). Upon passing through those doors the resident would potentially have to proceed through another set of cross corridor doors located adjacent to sleeping rooms 501 and 502 then proceed further through the magnetically locked exit door to an exterior gated area with a gate that is magnetically locked. Delayed egress locking, although permitted in health care occupancies, or portions of the building, is allowed provided there is not more than one (1) such device located in any egress path. With multiple locked cross corridor doors unlockable only by key pad, the access to exit doors is limited in worse case scenario of multiple fires or fires traveling in interstitial spaces and lack of alarm initiation.	K 043		

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K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This Standard is not met as evidenced by: Based on record review and staff interview, it was determined that the facility had not ensured that fire drills were documented as held as required for the last half of 2007 which would affect 68 of 68 residents. The findings include: Record review on September 9, 2008 at 4:30 p.m. disclosed that no documentation could be provided to show fire drills were held to include staff participation/training, problems encountered, times and dates. Paperwork had not been filled out to show drills had been completed for the last half of 2007 and staff stated during interview on September 9, 2008 at 4:30 p.m. that no records were available. Lack of fire drills would affect staff performance in removing residents from smokey situations.	K 050	This standard was not met in finding paper work. However, I was assured by multiple employees (laundry/hskp supervisor, HR, medical records, dietary manager, marketing) that in fact, drills were held at a minimum of 1 per shift each quarter. To ensure documentation of fire drills, in the future are not misplaced, a copy will be submitted to the NHA for the in-service notebook, and a copy will be kept in the maintenance office files. Start Sept. 15, 2008	
K 064 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10	K 064		

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K 064	Continued From page 5 This Standard is not met as evidenced by: Based on observation, it was determined that the facility had not ensured that fire extinguishers were maintained as required. The census was 68. The findings include: Observation on September 9, 2008 at 3:30 p.m. disclosed that the K-Class fire extinguisher installed in the kitchen was subject to recall within the past 3 years. No placard had been placed on the unit to show that a fire extinguisher company had replaced the necessary parts to keep the unit in service without potential for faulty operation if used. The unit serial number was 246718 and fell within the recall range of serial numbers for the company of manufacture (serial numbers 245001-249000). Lack of a nominally functioning portable fire extinguishing unit would potentially cause a grease/range fire to get out of control.	K 064	√ The K-class fire extinguisher serial #246718 was replaced with a new approved 6 litre K-class fire extinguisher. Sept. 26, 2008	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		

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K 144	Continued From page 6 This Standard is not met as evidenced by: Based on record review and staff interview, it was determined that the facility had not ensured that the maintenance log for generator was maintained as required. The census was 68. The findings include: Record review on September 9, 2008 at 4:05 p.m. disclosed that the generator log for monthly testing and weekly inspections was not maintained. The only documentation to show generator testing was for the months of January and February 2008 and an incomplete entry for March 2008. Staff stated during the record review that no other paperwork or documentation was available. Lack of generator test documentation would potentially lead to poor generator performance/failure and affect 68 of 68 residents.	K 144	√ Corrective measures for log keeping are now being met, using a check list showing the following: oil level oil leaks, coolant level coolant leaks, block heater, charging system, run temp, run time. Sept 15, 2008	

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Bureau of Facility Standards

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C 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The facility is a single story structure of Type V(111) construction. The building is protected throughout by an automatic fire extinguishing system and a fire alarm system with full detection throughout including patient/resident sleeping rooms. The building was originally constructed in 1959 with an addition in 1985. There have been several minor additions and remodels with a major remodeling completed in 2001. The facility currently is licensed for 73 SNF/NF beds. The following deficiencies were cited during the annual fire/life safety survey conducted on September 10, 2008. The facility was surveyed under the Life Safety Code 2000 Edition, Existing Health Care Occupancy and in accordance with IDAPA 16.03.02 Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities. The surveyor conducting the survey was: Eric Mundell REHS Health Facility Surveyor Facility Fire/Life Safety and Construction Program	C 000	REFER TO Form 2567	
C 226	02.106 FIRE AND LIFE SAFETY 106. FIRE AND LIFE SAFETY. Buildings on the premises used as facilities shall meet all the requirements of local, state and national codes concerning fire and life safety standards that are	C 226		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Michael Lee | ENVIRO/MAINT DIRECTOR | 10-15-08

Bureau of Facility Standards

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C 226	Continued From Page 1 applicable to health care facilities. This Rule is not met as evidenced by: Refer to the federal CMS 2567 and K tags K017, K029, K043, K050, K064 and K144.	C 226		